STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the recertification and state licensure survey. This visit included the investigation of Complaint IN00090313. This visit resulted in an extended survey-immediate jeopardy, past non compliance. Complaint IN00090313- Substantiated, No deficiencies related to the allegations are cited. Survey dates: May 16, 17, 18, 19 and 23, 2011 Facility number: 000301 Provider number: 155341 AIM number: 100289090 Survey team: Marla Potts RN TC Melinda Lewis RN Sharon Whiteman, RN Census bed type: SNF/NF: 57 Total: 57 Census payor type Medicare: 9 Medicaid: 43 Other: 5 Total: 57	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sample: 15 Supplemental Sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 5-24-11 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0164 SS=E	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation the facility failed to ensure residents received privacy during personal care, Resident #39 was toileted by a CNA without closing the door, Resident #51 was not provided privacy while using the urinal, and Nurses failed to close curtains/door to provide privacy while performing accu checks to Residents #15, #17, #16, & #54, for 2 of 3 random residents observed for personal care and 4 of 5 residents observed for	F0164	It is the policy of Eastgate Manor to ensure resident are provided with privacy during care. Resident's 39, 51, 15, 17,16,and 54 have been assessed for negative psychosocial effects with none noted. The alleged deficit practice has the potential to affect all residents. : Rounds have been conducted three times daily across all shifts for two weeks to ensure resident privacy was being maintained. No privacy issues	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accu checks. This affected 1 of 15 sampled residents(Resident #15) and 5 of 6 random residents observed for privacy. Findings include: 1. On 5/16/11 at 3:15 p.m. , CNA #2, was observed standing in the open bathroom doorway of Resident #39, which adjoined the residents room. Any one walking into the room could see into the bathroom. Resident #39's room doorway was also open. Upon entry to the room, Resident #39 was observed sitting on the toilet with CNA#2 standing in the doorway of the bathroom. The CNA had not provided privacy for the resident. 2. On 05/16/11 at 11:22 a.m., LPN #1 was observed to performing an accu check on Resident #15, in the residents room. LPN #1 was observed to not close		were noted. Nursing staff have been re-educated on resident rights to include providing privacy while providing care. Including but not limited to knocking on closed doors prior to entering room, closing doors or privacy curtains while proving care to promote privacy and ensuring the residents are inside their rooms behind a curtain or closed door while care is being provided. The DON/designee will conduct daily rounds Monday through Friday and the weekend manager will make unit rounds on Saturday and Sunday to ensure privacy is being provided when care is being given. The DON/designee will make walking rounds 3 x's daily for 2 weeks to ensure resident privacy and dignity are consistently observed and daily thereafter. Identified non compliance will result in one to one education with progressive discipline up to and including termination for failure to follow policy. Results of the monitoring will be presented to the Quality Improvement Committee for additional review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the door nor pull curtains while performing the accu check. 3. On 05/16/11 at 11:26 a.m., LPN #1 was observed to not close the door nor close curtains while performing an accu check on Resident #17, in the residents room, in the residents room. 4. On 05/16/11 at 11:29 a.m., LPN #1 was observed to not close the door nor close curtains while performing an accu check on Resident #16. 5. On 05/17/11 at 9:45 LPN #3 was observed to hand Resident #51 a urinal. The resident was observed to be seated in his room. The resident was seated in a wheelchair, just inside his open doorway. The resident's roommate was observed to be present in the room at the time. LPN #5 was observed to not pull a curtain around the resident nor close the resident's door. A female resident (Resident #46) was observed to be propelling herself past the resident's door in a wheelchair. The female resident indicated, "Everybody can see you honey." The door was observed to partially close from the inside. 6. On 05/17/11 at 5:00 p.m., LPN #2 was observed to perform an accu check and administer an insulin injection into Resident #54's abdomen. The resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was observed to be in her room. The resident was seated in a wheelchair, just inside the open door. LPN #2 was observed to not move the resident, nor close the door while administering the injection. 3.1-3(p)(2) 3.1-3(p)(4)			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review the facility failed to ensure residents were treated by staff members in a respectful manner in that staff were interacting with others by utilizing cell phones while providing care to residents rather that conversing and interacting with the resident, for 1 of 10 observations of personal care observed, and the facility failed to ensure a resident who required a urinal Resident #51 was provided the urinal in a manner to assure his dignity, for 1 of 6 random residents observed for	F0241	It is the policy of Eastgate Manor to provide care for residents in a manner that maintains or enhances each residents dignity and respect in full recognition of his or her individuality. Resident's 39, 3, and 51 were assessed for negative psychosocial effects with none noted. This alleged practice has the potential to effect all residents in the facility. Rounds have been conducted three times daily across all shifts for 2 weeks to ensure residents were provided care with respect and	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care. The president of resident council was interviewed and gave permission for resident council minutes to be reviewed, which indicated cell phone use by staff had been a concern of the council. CNA #2, Resident #39, Resident #3, Resident #51, Resident #46 Findings include: 1 On 5/16/11 at 3:15 p.m. , CNA #2, was observed standing in the open bathroom doorway of Resident #39, which adjoined the residents room. Any one walking into the room could see into the bathroom. Resident #39's room doorway was also open. Upon entry to the room, Resident #39 was observed sitting on the toilet with CNA#2 standing in the doorway of the bathroom. The CNA was observed to have her cell phone in her hand and to be looking at the screen and appeared to be texting. The CNA after a few seconds placed the cell phone back into the pocket of her uniform. During interview with Resident #39 on 5/16/11 at 3 p.m. the resident indicated the staff use phones sometimes and ignore you. She indicated the facility should take it away from them and the staff should spend their time working.		dignity. Observational rounds included the use of cell phones being used during care. No issues were noted. Nursing staff were re-educated on the importance of providing respect and dignity while providing care. Cell phone usage is not permitted in resident care areas or while employees are on company time. Identified non compliance will result in one to one education with progressive discipline up to and including termination for failure to follow policy. The DON/designee will monitor the units daily Monday through Friday and the weekend manager will make unit rounds Saturday and Sunday to ensure care is being provided with respect and dignity. The DON/designee will conduct walking rounds across all three shifts 3 x's daily for 2 weeks and daily thereafter to ensure resident care is provided with respect and dignity. As well as no cell phones are being used. . Results of the monitoring will be presented to the Quality Improvement Committee for additional review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident Council President, Resident #3 was interviewed on 5/16/11 at 9:30 A.M. and gave permission to review the council minutes. Resident council minutes from February and March 2011, indicated residents had expressed concern with staff members using cell phones while providing care. No concerns had been documented from the April 2011 meeting. A follow up form from the director of nursing, dated 2/18/11 indicated staff would be observed to ensure phones were only used for work related business. Another follow up, dated 4/6/11, indicated "any staff member not authorized to use cell phones for work purposes will be disciplined according to policy." 2. On 05/17/11 at 9:45 LPN #3 was observed to hand Resident #51 a urinal. The resident was observed to be seated in his room. The resident was seated in a wheelchair, just inside his open doorway. The resident's roommate was observed to be present in the room at the time. LPN #5 was observed to not pull a curtain around the resident nor close the resident's door. A female resident (Resident #46) was observed to be propelling herself past the resident's door in a wheelchair. The female resident indicated, "Everybody can see you honey." The door was observed to partially close from the inside.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-3(t)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop a care plan for an individualized toileting program for a resident who was frequently incontinent, Resident#7 and failed to ensure a care plan was developed for infection control related to c diff (clostridium difficile colitis), to ensure staff knew how to care for the resident to prevent the transmission of the organims, Resident #57, for 2 of 15 residents reviewed for development of care plans, in the sample	F0279	It is the policy of Eastgate Manor to utilize the results of assessments to develop review and revise the resident's comprehensive plan of care. Resident 7: Bowel and Bladder care plans have been reviewed and updated to reflect residents current status. Individualized toileting times were added to the CNA care guide.. Resident 57: The infection control care plan has been reviewed and revised to reflect residents current status. Resident specific isolation precautions have been placed on the	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of 15. Findings include: 1. The clinical record for Resident # 7 was reviewed on 5/16/11 at 11:00 A.M. The record indicated Resident # 7 had diagnoses that included but were not limited to cerebrovascular accident (stroke). The MDS [minimum data set] assessment, dated 3/2/11, indicated Resident # 7 had moderate cognitive impairment. Resident #7 required supervision with assist of one with bed mobility, supervision with assist of two for transfers. Resident # 7 was frequently incontinent of urine. A care plan, dated 1/15/11, indicated the problem of "Alteration in urinary continence- occasionally incontinent, frequently incontinent. Alert/Oriented, forgetful at xs [times], confused, able to make basic needs know (sic), functional incontinence (loss of urine caused by factors outside the lower urinary tract), leakage of small amounts of urine when the bladder has reached its maximum capacity and has become over distended." The interventions included but were not limited to "Schedule toileting/ habit training- resident is toileted at regular intervals to match residents voiding		CNA care guides. A one time 100% record review of current in house residents has been completed. Record review included but was not limited to physician's orders, bowel and bladder assessments, care plans as well as infection control care plans. Care plans were updated as needed to reflect residents current status. The CNA care guides have been updated to reflect individualized toileting schedules as well as isolation precautions. The IDT were re-educated on policy and procedure for developing care plans according to resident assessments to include individualized toileting schedules and isolation precautions. Nursing Administration will review physician orders, 24 hour report sheets and quarterly nursing data collection and assessment to determine residents with newly identified urinary incontinence or chronic urinary incontinence that would require assessment for possible scheduled toileting with care plan development. Nursing Administration will also review 24 hour report sheet and physicians orders to identify residents with signs and symptoms that may require development of an infection control care plan. Signs and symptoms include but are not limited to elevated WBC, temperature, cough, congestion, etc. Identified residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	habits. Residents who cannot toilet themselves may be a candidates for scheduled toileting e.g., Provide assistance at specific intervals during the day based upon voiding/incontinence pattern. Individualized times: (blank). Prompted voiding- Able to say name and reliably point to 2 objects. Focuses on teaching the resident to recognize bladder fullness, to ask for help, or respond when prompted to void, e.g., Provide verbal reminders at specific intervals during the day based upon voiding. incontinence pattern.. Assist as needed at specific intervals. Individualized times: (blank)." The care plan lacked any documentation of any specific times of when the resident was to be assisted to the toilet. A Bladder Data Collection And Assessment, dated 11/8/10, indicated "...In the past 14 days: Resident has always been incontinent of urine- yes. If yes, initiated 3-Day Elimination Tracking (Care Tracker). Review Care Tracker three day elimination tracking: frequently incontinent (tended to be incontinent daily, but some control present). Determine the resident's history of incontinence including: onset, duration, precipitant, and previous treatment. Onset: (blank). Duration: (blank) Precipitant: (blank) Previous treatments: (blank) Incontinent product: yes brief.		will be reviewed by the IDT to develop care plans based upon individualized resident assessments. Identified non compliance will result in one to one education with progressive discipline up to and including termination for failure to follow policy. DON/designee will audit the care plans and CNA care guides of 10% of incontinent residents weekly times 4 weeks then monthly thereafter to ensure they reflect the residents current status. DON/designee will review the care plan and the CNA care guide of 10% of residents with an active diagnosis of infection weekly times 4 weeks then monthly thereafter. Results of the audits will be presented to the Quality Assessment Committee for additional review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Potentially reversible (transient) causes of urinary incontinence- Conditions: dependent transfer(1 or 2 assist), diabetes, brain tumor induced psychosis, uterine fibroids, impaired mobility/ ambulation, decreased vision. Contributing diagnosis/ medical conditions- dementia, brain tumor, L [left] side hemiparesis, CVA, obesity, diabetes. Medication that may be contributing to bladder dysfunction- diuretic, psychotropic drugs, antihistamine...Incontinence symptoms profile- Functional urinary incontinence- mobility/ manual dexterity impairments, medication, depression, dementia. Treatment/ Management program placement- Scheduled voiding/ habit training- Resident is toileted at regular intervals to match resident's voiding habits. Residents who cannot toilet themselves may be a candidates (sic) for scheduled voiding..." This form was reviewed on 1/5/11 and 5/10/11 and indicated the resident was able to participate in bladder program. In an interview with CNA #13, on 5/17/11 at 1:45 P.M., which worked the hall that Resident # 7 resided on she indicated the CNA assignment sheet did not indicate the times Resident # 7 was to be assisted to the toilet. She stated as far as she knew it was only when Resident # 7 turned on her call light and requested assistance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 5/18/11 at 3:30 P.M., in an interview with the Education RN she indicated the resident was on a restorative nursing program for toilet use. She provided the plan for Resident # 7, dated 2/7/11, which indicated she was toileted before breakfast and lunch. The policy and procedure for Management of Urinary Incontinence,dated 1/2009, provided by the DoN on 5/23/11 at 9:00 A.M. indicated "inform care giving team of plan. Educate on techniques and interventions as indicated..." 2. Resident #57's clinical record was reviewed on 5/18/11 at 10:00 A.M. The resident was admitted 3/12/11 after a hospital stay with diarrhea and dehydration related to C-Diff. He returned from another hospital stay, on 5/2/11 with diagnoses, which included, but were not limited to, acute congestive heart failure and "acute or chronic c-diff colitis." The resident returned with antibiotics of vancomycin and flagyl to treat the C-diff. A progress note dated 5/3/11, indicated "c-diff reactivated while at hospital."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nurses notes indicated: "5/2/11 at 4 p.m. indicated: "Patient readmitted..diarrhea continues contact isolation for c-diff precautions in room and outside door..." "5/8/11 1200 p.m. ...up to bathroom with wheelchair....diarrhea continues vancomycin and flagyl continues..." "5/11/11 1030 p.m. ...toilets self, uses urinal at times..." "5/12/11 2000 (8 p.m.)propels self in wheelchair, continent of bowel and bladder toilets self..." "5/13/11 1435(2:45 p.m.) continues vancomycin and flagyl for c-diff as ordered. toilets self..." During interview with the DoN and LPN #4, Resident #57's charge nurse, on 5/18/11 at 12:10 p.m., they indicated the resident should have a bedside commode in his room. They indicated he had been clear of C-Diff before a recent hospitalization but had returned on medications for Chronic C-Diff. LPN #4 indicated he used the toilet in his bath room. The DoN indicated he used a urinal and staff would have known to clean the bathroom, as they had to help him to toilet. Both agreed his roommate would also used the same bathroom. The DoN indicated she would have a commode placed in the room for Resident #57. She indicated it was removed when he tested clear for c-diff prior to the most			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	recent hospital stay and had not been placed back in the room. She indicated the hospital routinely treated residents for c-diff and she did not know if he had actually been tested again for c-diff during the hospital stay. During interview with Resident #57 on 5/18/11 at 10:00 A.M. he indicated the facility use to have a bedside commode in his room and had to clean the toilet with a special cleaner after he used it, but had not had to do that since his return from the hospital. The care plan, included a problem, dated 3/21/11 and updated 5/3/11, for "actual/potential for infection related to IV and cdiff 3/18/11, resolved 4/20/11." Interventions included but were not limited to: 'isolation as needed for policy. contact 3/21/11." The care plan had not been updated to include the need for isolation after the hospital stay and what specific measures were needed to protect other residents residing in the facility. 3.1-35(b)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of urine had a plan developed based on the assessment, and then implemented to restore as much bladder continence as possible, for 1 of 5 residents reviewed with incontinence, in the sample of 15. Resident # 7 Findings include: On 5/16/11 at 9:00 A.M., the Assistant Director of Nursing indicated Resident # 7 was a recent readmission from the hospital. He indicated Resident # 7 had a recent fall resulting in a laceration to the foot which required 5 sutures. He further indicated Resident # 7 was not interviewable. The clinical record for Resident # 7 was reviewed on 5/16/11 at 11:00 A.M. The	F0315	It is the policy of Eastgate Manor that based on the resident's comprehensive assessment the facility provides services to restore as much normal bladder function as possible. Resident 7 has been reviewed Bowel and bladder assessments and care plans have been updated to reflect current status. CNA care guides have been updated to reflect the residents individualized toileting plan. A one time 100% record review has been completed on in house residents. Record review included but was not limited to physicians orders, comprehensive nursing data and collection assessment, quarterly nursing data collection and assessments, bowel and bladder assessments as well as resident's bowel and bladder ace plans. Bowel and Bladder assessments and care plans were updated as needed to ensure the resident toileting programs were individualized. CNA care guides were updated to include	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record indicated Resident # 7 had diagnoses that included but were not limited to cerebrovascular accident (stroke). The MDS [minimum data set] assessment, dated 3/2/11, indicated Resident #7 had moderate cognitive impairment. Resident #7 required supervision with assist of one with bed mobility, supervision with assist of two for transfers. Resident # 7 was frequently incontinent of urine. A care plan, dated 1/15/11, indicated the problem of "Alteration in urinary continence- occasionally incontinent, frequently incontinent. Alert/Oriented, forgetful at xs [times], confused, able to make basic needs know (sic), functional incontinence (loss of urine caused by factors outside the lower urinary tract), leakage of small amounts of urine when the bladder has reached its maximum capacity and has become over distended." The interventions included but were not limited to "Schedule toileting/ habit training- resident is toileted at regular intervals to match residents voiding habits. Residents who cannot toilet themselves may be a candidates for scheduled toileting e.g., Provide assistance at specific intervals during the day based upon voiding/incontinence pattern. Individualized times: (blank). Prompted voiding- Able to say name and		residents specific toileting schedules. Nursing staff to include IDT were re-educated on policy and procedure for developing individualized toileting schedules based on resident assessment. Nursing Administration will review physician orders, 24 hour report sheets, Admission Comprehensive Data Collection Assessment and Quarterly Nursing Data Collection and Assessment to determine residents with newly identified urinary incontinence that would require assessment for possible individualized scheduled toileting. Identified residents will be reviewed by the IDT to develop an individualized toileting plan. CNA care delivery guide will be updated to reflect the resident's toileting plan. DON/designee will audit the care plans and CNA care guides of 10% of incontinent residents weekly times 4 weeks then monthly thereafter to ensure they reflect the residents current status. The results of the audit will be presented to the Quality Assessment Committee for additional review and recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reliably point to 2 objects. Focuses on teaching the resident to recognize bladder fullness, to ask for help, or respond when prompted to void, e.g., Provide verbal reminders at specific intervals during the day based upon voiding. incontinence pattern.. Assist as needed at specific intervals. Individualized times: (blank)." A Bladder Data Collection And Assessment, dated 11/8/10, indicated "...In the past 14 days: Resident has always been incontinent of urine- yes. If yes, initiated 3-Day Elimination Tracking (Care Tracker). Review Care Tracker three day elimination tracking: frequently incontinent (tended to be incontinent daily, but some control present). Determine the resident's history of incontinence including: onset, duration, precipitant, and previous treatment. Onset: (blank). Duration: (blank) Precipitant: (blank) Previous treatments: (blank) Incontinent product: yes brief. Potentially reversible (transient) causes of urinary incontinence- Conditions: dependent transfer(1 or 2 assist), diabetes, brain tumor induced psychosis, uterine fibroids, impaired mobility/ ambulation, decreased vision. Contributing diagnosis/ medical conditions- dementia, brain tumor, L [left] side hemiparesis, CVA, obesity, diabetes. Medication that may be contributing to bladder dysfunction-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diuretic, psychotropic drugs, antihistamine...Incontinence symptoms profile- Functional urinary incontinence- mobility/ manual dexterity impairments, medication, depression, dementia. Treatment/ Management program placement- Scheduled voiding/ habit training- Resident is toileted at regular intervals to match resident's voiding habits. Residents who cannot toilet themselves may be a candidates (sic) for scheduled voiding..." This form was reviewed on 1/5/11 and 5/10/11 and indicated the resident was able to participate in bladder program. In an interview with CNA #13, on 5/17/11 at 1:45 P.M., which worked the hall that Resident # 7 resided on she indicated the CNA assignment sheet did not indicate the times Resident # 7 was to be assisted to the toilet. She stated as far as she knew it was only when Resident # 7 turned on her call light and requested assistance. On 5/18/11 at 3:30 P.M., in an interview with the Education RN she indicated the resident was on a restorative nursing program for toilet use. She provided the plan for Resident # 7, dated 2/7/11, which indicated she was toileted before breakfast and lunch. 3.1-41(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident with frequent falls was provided interventions to prevent future falls from her bed, in that the resident fell from the bed resulting in sutures to her right foot, for 1 of 6 residents reviewed with falls in the sample of 15. Resident # 7 Findings include: On 5/16/11 at 9:00 A.M., the Assistant Director of Nursing indicated Resident # 7 was a recent readmission from the hospital. He indicated Resident # 7 had a recent fall resulting in a laceration to the foot which required 5 sutures. He further indicated Resident # 7 was not interviewable. On 5/18/11 at 3:30 P.M., Resident # 7 was observed to be in a low bed that was against the wall with a thin mat on the other side of the bed. Resident # 7 was	F0323	It is the policy of Eastgate Manor to ensure that the resident environment remains as free of accident hazard as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. Resident 7 has been reviewed and a bariatric bed was obtained. Resident fall assessment and care plan have been updated to reflect resident's current status. A one time 100% record review of care plans/fall assessments has been completed for residents with falls in the past 30 days; interventions were deemed appropriate. Nursing staff were re-educated to policy and procedure for accident prevention, safety equipment, and assistant devices. Re-education included providing appropriate interventions. Residents newly identified as having a fall risk or after a fall will be reviewed by the interdisciplinary team to ensure that appropriate interventions are in place and that current interventions remain appropriate and individualized for the resident.	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed to have her left leg hanging over the side of the bed. The clinical record for Resident # 7 was reviewed on 5/16/11 at 11:00 A.M. The record indicated Resident # 7 had diagnoses that included but were not limited to cerebrovascular accident (CVA- stroke). The MDS [minimum data set] assessment, dated 3/2/11, indicated Resident #7 had moderate cognitive impairment. Resident #7 required supervision with assist of one with bed mobility, supervision with assist of two for transfers. Resident # 7 had fallen and received an injury since the previous assessment completed within the last 90 days. An Accident/Incident Report, dated 12/15/10 at 5:25 P.M., indicated "...CNA went to pts [patients] room to bring down for eve [evening] meal found pt on floor by the foot of bed was sitting in w/c (wheelchair) with blankets over her prior too (sic). No injury...Immediate action taken to prevent further incidents: Neurochecks started, sent to ER [emergency room] for change in condition..." An Accident/Incident Report, dated 12/25/10 at 7:00 P.M., indicated "...pt st [stated] "was bending over to pick up		The Director of Nursing/Designee will conduct compliance rounds utilizing Fall Prevention Compliance Audit to ensure appropriate interventions are in place daily x 4 weeks, 2x weekly x 4 weeks and weekly thereafter. The results of the above audit will be presented to the Quality Assessment Committee for additional review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	piece of paper et [and] slid out of w/c on to floor, denys (sic) hitting head or pain...Immediate action taken to prevent further incidents: reminded pt not to pick things up off floor and to use call light for assistance with ambulation/movement..." An Accident/Incident Report, dated 12/31/10 at 3:00 A.M., indicated "...Heard pt say "help" upon entering pt's room found pt on floor sitting on L [left] side of bed. Pt states that she rolled out of bed...Immediate Action taken to prevent further incidents: Neurochecks, ROM [range of motion], Will attempt low bed..." A care plan, dated 1/5/11 and updated on 2/16/11 and 4/3/11, indicated a problem of "Fall/injury assessment: prevention and management plan of care. Fall/injury risk related to: pain, stiffness, osteoarthritis, unsteady, high blood sugar, low blood sugar, cardiovascular diagnosis, bowel incontinence, bladder incontinence, CVA, hearing increased wax in ears, numb/tingling feet, cardiovascular meds [medications], antidepressant, hx [history] of fall/injury: 12-15-10, 12-25-10 fell out of chair reaching for item on floor, 12-31-10, 2/21/11 out of w/c, 3-12-11 fall, 5-14-11 fall." The interventions included but were not limited to "1-7-11 low bed, reaching device, grab bars, reacher, low			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bed 1-10-11, 12-15-10 sent to ER confused with cystitis ATB [antibiotic] tx [treatment], 12-25-10 provide reacher device/ dysem under chair." A DCR [daily clinical review] note, dated 2/16/11, no time, indicated "Reviewed current safety plan to ensure POC [plan of care] is appropriate for resident. Resident low bed appropriate at this x [time]. Resident cont [continues] with positioning bars x 2 to allow res to help turn self et reposition self as needed. Resident up ad lib in room with walker but needs assist of 1 out of room. Will cont to review as needed." The Nurses Notes, dated 2/21/11 at 7:30 P.M., indicated "Pt fell in room has a small hematoma with abrasion to top of head all other exts [extremities] have good ROM. No c/os of (sic) pain except headache...Pt not sure what happened. Neurochecks initiated...Will have therapy look at w/c for trying modifications." The fall care plan, dated 1/5/11, was updated on 2/21/11 to include the intervention of U/A [urinalysis] C & S [culture and sensitivity], OT [occupational therapy] eval [evaluate] and tx [treat] for w/c modifications add lower shelf in room."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The fall care plan, dated 1/5/11, was updated on 2/22/11 to include the intervention of spoke with resident re: alarms; Res [resident] refuses becomes upset. An Accident/Incident Report, dated 3/12/11 at 9:15 A.M., indicated "...Resident in room reached forward to place stuff on shelf. Brakes not locked. Resident slid out of chair fell on buttocks. Resident denies hitting head or any pain...Immediate action taken to prevent further incidents: Head to toe assessment. PT [physical therapy] screen requested, placed on 15 min [minute] checks until further notice..." The fall care plan, dated 1/5/11, was updated on 3/12/11 to include the intervention of .PT screen, 15 min obs [observations] An Accident/Incident Report, dated 5/9/11 at 2130 (9:30 P.M.), indicated "...Resident sitting in w/c looking through clothes et leaned forward and brushed face against box. No injury...Immediate action taken to prevent further incidents: nurse assisted resident in cleaning out closet and organizing clothes..." An Accident/Incident Report, dated 5/14/11 at 0230 (2:30 A.M.), indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"...Heard trash can knock over et went in rm [room] to find res [resident] on knees on floor holding onto rm mates bed with head nest to trash can. Res alert et responded to name, assisted to sitting position gave glucagon 1 mg IM in R [right] arm et assisted res in drinking 200 cc OJ [orange juice] at 0245 (2:45 A.M.) BS [blood sugar] up to 40 at 0300 (3:00 A.M.) BS 60 et res A&O x [alert and oriented times] 3 denies pain. Lg [large] amt [amount] of blood noted under res coming from R ft [foot] little toe, noted laceration to underneath side of toe scattered bruises to R arm et bruise to R side of chin which res stated was from hitting box on 5/9/11. Bruise- scattered. Laceration- 3 cm....Immediate action taken to prevent further incidents: cleansed toe et applied dry dsg [dressing], notified MD et sent res to ER. Moved bed against wall in low position et applied mat to floor beside bed d/t [due to] res ref [refused] alarms..." The fall care plan, dated 1/5/11, was updated on 5/14/11 to include the intervention of bed next wall, matt (sic) to floor. A Physician order, dated 5/15/11, indicated "Remove sutures R toe on 5/24/11."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0334 SS=D	The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on interview and record review, the facility failed to document the education of residents who refuse to have the influenza vaccination for 2 of 15 residents reviewed for the annual influenza vaccination in a sample of 15. Resident # 8 and 15 Findings include: 1. The clinical record for Resident # 8 was reviewed on 5/18/11 at 4:00 P.M. The record indicated Resident # 8 had diagnoses that included but were not limited to mental retardation and seizure disorder. The MDS [minimum data set]	F0334	It is the policy of Eastgate Manor that each resident or residents legal representative are provided with education regarding the benefits and potential side effects of the influenza immunization annually upon refusal. Education has been provided to the responsible parties for #8 and #10 related to the risks and benefits of annual flu immunizations. A one time 100% record review of current in-house residents has been completed to identify residents with current refusals of the flu immunization. The responsible parties of identified residents have been contacted and education provided. : The IDT has been re-educated to the policy and procedure for	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 3/17/11, indicated Resident # 8 had moderate cognitive impairment. A Pneumococal, Tetanus-Diphtheria and Annual Influenza Vaccine Information and Request form, dated 5/29/09, indicated the responsible party for Resident # 8 had refused the pneumococcal and annual influenza vaccines. The Immunization Record, dated 5/29/09, was filled to include the following information: "immunization history prior to admission was blank and the Immunizations administered while resident in the facility indicated "Influenza- refused 11/5/10." During an interview with the Director of Nursing, on 5/19/11 at 9:00 A.M., she indicated the responsible party was provided with the education information concerning the influenza vaccine but that there was no documentation that it was provided. 2. The clinical record for Resident # 15 was reviewed on 5/18/11 at 3:15 P.M. The record indicated Resident # 15 had diagnoses that included but were not limited to dementia.		immunizations to include education to residents and or responsible party members for refusals. Residents and/or responsible parties who refuse the annual influenza vaccination will be educated per facility policy and this education will be documented on the Pneumo/Flu vac information request form. Identified non compliance will result in one to one education with progressive discipline up to and including termination for failure to follow policy. Residents with refusals are taken before the IDT to ensure documentation of education has been completed. Monitoring will be conducted at the beginning of the influenza season and will cease at the end of the season. Audits will be presented to the Quality Assessment committee for review and recommendations during the appropriate months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The MDS [minimum data set] assessment, dated 3/11/11, indicated Resident # 15 had severe cognitive impairment. The Immunization Record, dated 11/3/08, indicated "Immunization History Prior to Admission- Influenza- ref [refused] on adm [admission]. Pneumococcal- ref on adm. Immunizations administered while residing in the facility- Influenza- 10/09- Refuses." The remainder of the form was blank. In an interview with the Director of Nursing, on 5/19/11 at 9:00 A.M., she indicated the responsible party was provided with the education information concerning the influenza vaccine but that there was no documentation that it was provided. She indicated she did not know why there was no documentation of Resident # 15 receiving or refusal of the influenza vaccine for 2010. 3. The facility policy and procedure for Influenza Vaccinations was provided by the Director of Nursing on 5/18/11 at 2:00 P.M. The policy indicated "...The resident...will sign a form stating they have been informed of benefits and adverse effects. Forms will be filed in the medical record...Review with resident...the benefits and adverse effects			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of each vaccine prior to administration..." 3.1-13(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview the facility failed to post the nursing staffing data on a daily basis for 1 of 4 days reviewed in that upon entry to the facility on 5/16/11 the Daily Nurse staffing form posted was dated 5/11/11. This had the potential to affect 57 of 57 residents and or their responsible parties.	F0356	It is the policy of Eastgate Manor to post daily nursing staffing hours. No individual residents identified as being affected. The Licensed nurses responsible for posting of the staffing hours and the management team were re-educated to post the nursing hours on a daily basis Monday through Friday. The	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: The Daily Nurse Staffing Form was observed on 5/16/11 at 9:00 A.M. to have been hanging in the hallway by the main office door. The posting was dated 5/11/11. The form included the total number and actual hours worked by Registered Nurses, Licensed Practical Nurse and Certified nursing aides, but did not include the census. The Assistant Director of Nursing, on 5/16/11 at 9:30 A.M. indicated LPN #1 was responsible for staffing and the daily posting. During interview with LPN #1 on 5/16/11 at 9:30 A.M. indicated she normally did hang them but had been working the floor and just not got them out. 3.1-13(a)		nurse on station one will post the staffing sheets on the week ends. Identified non compliance will result in one to one education with progressive discipline up to and including termination for failure to follow policy. The DON/Designee will audit the staffing sheet daily Monday through Friday. The Weekend manager will monitor the staffing sheets on the weekends. Audits will be reviewed by the Quality Assessment committee for additional review and recommendations.	
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation the facility failed to ensure dietary staff washed their hands after touching kitchen equipment and	F0371	It is the policy of Eastgate Manor to store, prepare, distribute, and serve food under sanitary conditions. No individual residents were identified	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	prior to returning to dip up of meal and prior to handling plates and bowls. These observations were made during 1 of 3 kitchen observations. This had the potential to affect 57 of 57 resident who received food and or fluids from the kitchen. Findings Include: On 05/16/11 at 11:45 a.m. with the Dietary Manager present during dip up of the noon meal the following observations were made: 1. Cook #20 was observed to dip up food for the noon meal. Cook #20 was observed to step away from the steam table and to handle the oven door while opening the door and to not wash her hands before returning to the steam table and continuing with dip up of the meal. 2. Cook #20 was observed to touch the handle of the silverware drawer while opening the drawer and to not wash her hands before returning to the steam table and dipping of food. 3. Cook #20 was observed to place her fingers in the bowls used to dip corn into prior to serving.		to be effected. This alleged deficit practice has the potential to affect all residents. Dietary staff will be re-educated on proper hand washing to include return demonstration as well as maintaining proper sanitation while preparing and serving food. The dishes were inverted to eliminate the chance of touching the surface of the plates. The tray line will be inspected prior to serving to reduce/eliminate the need to leave the tray line. Other dietary staff can retrieve what may be needed. Identified non compliance will result in one to one education with progressive discipline up to and including termination for failure to follow policy. The dietary manager/designee will monitor to a minimum of two meals per day 5 x week for 2 weeks for sanitary preparation and serving of food. Monitoring will be continued 3 times a week for 3 months. Results will be reviewed by the Quality Assessment committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. Cook #20 was observed to step away from the steam table 4 times and to not wash her hands prior to pushing the button on the plate warmer and placing the palm of her hand on the top plate to push the plates down before picking up extra plates to use for the noon meal. 3.1-21(a)(3)			
F0428 SS=D	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on interview and record review, the facility failed to ensure the pharmacist reviewed and made recommendations for necessary labs to monitor coumadin, in that Resident #29 was receiving Coumadin without orders for PT/INR (blood work to monitor clotting) in order to monitor the needed dose, and the pharmacist did not report this irregularity, for 1 of 15 residents reviewed for pharmacy recommendations, in the sample of 15.	F0428	It is the policy of Eastgate Manor that the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist and any irregularities be reported to the attending physician/ DON and these reports must be acted upon. During medical rounding of residents the physician of resident #29 provided order for routine monitoring of coumadin on date. Resident # 29 has been assessed will no negative effects noted. It is the	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident # 29 Findings include: On 5/16/11 at 9:00 A.M., on the initial tour the Assistant Director of Nursing indicated Resident # 29 had dementia, a history of falls, was up in a wheelchair daily, required assistance of two with transfers and was not interviewable. Resident # 29 was observed at this time to be in bed asleep. The clinical record for Resident # 29 was reviewed on 5/17/11 at 2:00 P.M. The record indicated Resident # 29 had diagnoses that included but were not limited to atrial fibrillation (a fib), cerebrovascular accident (CVA- stroke) and history of deep vein thrombosis (DTV). The MDS [minimum data set] assessment, dated 3/24/11, indicated Resident # 29 had severe cognitive impairment. Resident # 29 required extensive assistance of two with bed mobility, transfers, ambulation and toilet use. Resident # 29 had fallen one time without injury since the previous assessment dated 2/20/11. A Hospital Consultation, dated 11/18/10, indicated "...Coumadin (blood thinner) toxicity with INR [International		intent of Eastgate Manor to monitor lab work as necessary. A 100% one time record review of current in-house residents receiving coumadin has been completed. No other residents receiving coumadin were identified as not having routine monitoring orders. Per telephone conversation with the Administrator the consultant pharmacist was re-educated on the policy and procedure for drug regimen review and reporting irregularities to the physician and DON. In conclusion of consultant pharmacist review, the consultant pharmacist will exit with the DON to report any irregularities. The DON/Designee will conduct a monthly coumadin audit to verify that consultant pharmacist has identified any resident lacking routine coumadin monitoring orders. Results of the monitoring will be reviewed by the Quality Assessment Committee for additional review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Normalization Ratio] very high. Etiology is not clear, but could be due to medications. At this time will hold her Coumadin. She is not bleeding anywhere so I am not going to give her Vitamin K because she has a history of deep venous thrombosis in the past. I will see how she does. Hemoglobin is stable, we will restart her Coumadin with a lower dose once her INR is less than 3..." The Medication Regimen Review indicated the pharmacist had reviewed Resident # 29's medications on 12/29/10 without mention of the need to monitor her blood due to receiving routine Coumadin. The pharmacist reviewed the medications on 1/25/11 without mention of the need to monitor her blood due to Coumadin use. The pharmacist reviewed the medications in 2/11 without recommendations for monitoring Resident # 29's blood levels. A Pharmacy Recommendation, dated 3/29/11, indicated "...(Resident # 29) takes warfarin (Coumadin) and the most recent INR documented in the resident record is from 2/16/11. (A one-time order was written on 2/4/11 and then checked again 2/16/11 due to a dosage change, but no further lab has been ordered). Recommendation: Please consider monitoring an INR on the next convenient			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lab day and at least monthly thereafter, with more frequent monitoring if the individual has a change in condition, diet or medication regimen. Rationale for recommendation: The manufacturer's prescribing information includes a BOXED warning describing an increase potential for serious bleeding events. Other medications, diet, changes in patient conditions, etc. may affect anticoagulant therapy..." In an interview with the Director of Nursing, on 5/18/11 at 4:00 P.M., she indicated the facility did not have a policy and procedure for lab monitoring of residents receiving Coumadin. She further indicated she did not know why the pharmacist had not found Resident # 29 had not had any monitoring of her blood for this. 3.1-25(i)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review the facility failed to ensure infection control measures were implemented to control the potential	F0441	It is the policy of Eastgate Manor to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease. Resident 57: was provided a bedside	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	spread of infections in that staff failed to ensure they washed their hands and changed gloves as necessary for the prevention of the spread of infection during care, accu check testing of blood sugars, administering insulin injections, and the passing of ice water, for 8 of 15 sampled residents (Resident #57, 29, 40, 15, 45, 54, 17 and 16) reviewed for infection control in the sample of 15, and 3 of 5 random residents (Resident # 39, 48, 14 and 43) observed for care and infection prevention. This had the potential to affect 57 of 57 residents who resided in the facility and received care from the facility staff. Findings include: 1. The policy and procedure of Clostridium-difficile (c-diff) Preventing Spread, dated 11/10, was provided by the Assistant Director of Nursing on 5/17/11 at 5:00 P.M. The policy indicated, "Clostridium-difficile organism causes gastrointestinal infections that range in severity form asymptomatic colonization to severe diarrhea, colitis, toxic megacolon and possible death. The laboratory test recommended for diagnosisng C-dif diseases is the toxin assay test...Residents diagnoses with Clostridium difficile shall be placed on Contac Precautions.. If the C-diff resident		commode and a sign was placed on the door for visitors to contact the nurse prior to entering the room. The precaution instructions were placed in the isolation cart. Residents 29, 40, 15, 25, 54, 17, 16, 39, 48, 14, and 43 were assessed for signs and symptoms of infection with none noted. Signs and symptoms include but are not limited to elevated WBC, temperature, cough, congestion, etc. This alleged deficit practice has the potential to affect all residents. A one time 100% clinical record review of current in house residents has been completed to identify residents with signs and symptoms of infection with none noted. Nursing staff have been re-educated to policy and procedure for infection control prevention. Re-education included but not limited to hand washing, the proper use of gloves, handling of linen, and personal protective equipment. Return demonstrations of hand washing, proper use of gloves, and how to remove personal protective equipment will be conducted on nursing staff. The DON/designee will conduct daily rounds Monday through Friday and the weekend manager will make unit rounds on Saturday and Sunday to ensure infection control practices are being utilized. Identified non compliance will result	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	has uncontrolled or uncontained stool they shall be placed in a private room if at all possible...room with a dedicated bathroom or use a bedside commode...If the C-diff resident has controlled or contained stool or toilets self, they may be placed in a room with another C-diff infected resident, room with a shared bathroom or Room with a resident that is not immune compromised...wear clean, non sterile gloves when entering a room of a C-diff infected resident...wear clean non sterile gowns when entering the room of a C-diff resident due to environmental significance of the organisms spores..cleanse residents hands thoroughly before leaving the resident's room s and wash hands immediately with plan soap. Ensure clothing and hands do not come in contract with environmental surfaces potentially contaminated with C-diff (eg door knob) after removal of gloves and gown. The policy and procedure for "Hand Hygiene-plain soap and water handwash," dated 4/10, provided by the DoN on 5/23/11 at 10:30 A.M. indicated "Hand Hygiene is the most important step for preventing Healthcare associated infections...plain soap and water handwash may be used ...before handling direct contact with residents...after contact with a residents intact skin (e.g. when		in one to one education with progressive discipline up to and including termination for failure to follow policy. DON/designee will conduct observational walking round 3 times daily x 2 weeks, then 5 times weekly thereafter to ensure infection control practices are being utilized. Results of the walking rounds audit will be reviewed by the Quality Assessment Committee for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	taking a pulse or blood pressure, and lifting a resident) after contact with body fluids or excretions, mucous membranes, non intact skin and wound dressings if the hands are not visibly soiled, after removing gloves..." 2. Resident # 57 was identified on the initial tour of the facility by the Director of Nursing, on 5/16/11 at 9:45 A.M. as being in a wheelchair and propels himself about the facility. A nightstand was observed sitting outside the residents door way. The resident shared the room with another resident who was up ad lib and ambulated about the facility. A bathroom adjoined the room. No bedside commode was observed in the room and there was no signs on the door. Barrels were observed in the room for linens. On 5/16/11 at 1:00 p.m., Housekeeper #1, indicated the night stands outside the rooms contained isolation equipment. She indicated she would ask nursing what she was to do and she would use the equipment in the drawers. CNA #2 indicated on 5/16/11 at 1:00 P.M. Resident #57 was on isolation related to C-Diff, his linens were kept separate and there was barrels in this room, he was normally up and about in the wheelchair			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and only used the bathroom in his room. She indicated staff would know isolation from report each day. During interview on 5/16/11 at 1:45 P.M., the DoN, indicated Resident #57 and any others with infections which required isolation should have signs on the doors to check with nurse before entering. The DoN indicated she did not know where the signs were and had placed a new sign on the doors. On 5/18/11 at 10:15 A.M. CNA #5 was observed to put on an isolation gown and gloves and enter Resident #57's room. She was observed to pick up Resident #57's water glass with her gloved hands, empty the water in the bathroom sink, go out into the hall, take the ice scoop from the container and proceed to give the resident more ice from the cooler and return the glass to his room. CNA #5 removed her gown and gloves, went to the soiled utility room washed her hands, and went back to Resident #57's room. CNA #5 then went into the room and picked up Resident #56's (Resident #57's roommate) ice water cup, take it to the cooler and use the ice scoop to obtain ice from the cooler and place it into the cup. CNA #5 was not observed to obtain a new scoop or to clean the ice scoop after touching it with her gloved hands while obtaining			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #57's ice. During interview with the DoN and LPN #4, Resident #57's charge nurse, on 5/18/11 at 12:10 p.m., they indicated the resident should have a bedside commode in his room. They indicated Resident #57 had been clear of C-Diff before a recent hospitalization but had returned on medications for Chronic C-Diff. LPN #4 indicated Resident #57 used the toilet in his bath room. The DoN indicated Resident #57 used a urinal and staff would have known to clean the bathroom. Both agreed his roommate would also use the same bathroom. The DoN indicated she would have a commode placed in the room for Resident #57. She indicated it was removed when he tested clear for c-diff prior to the most recent hospital stay and had not been placed back in the room. She indicated the hospital routinely treated residents for c-diff and she did not know if he had actually been tested again for c-diff during the hospital stay. During interview with Resident #57 on 5/18/11 at 10:00 A.M. he indicated the facility use to have a bedside commode in his room and had to clean the toilet with a special cleaner after he used it, but had not had to do that since his return from the hospital.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #57's clinical record was reviewed on 5/18/11 at 10:00 A.M. The resident was admitted 3/12/11 after a hospital stay with diarrhea and dehydration related to C-Diff. He returned from another hospital stay, on 5/2/11 with diagnoses, included but were not limited to, acute congestive heart failure and "acute or chronic c-diff colitis." The resident returned with antibiotics of vancomycin and flagyl to treat the C-diff. A progress note dated 5/3/11, indicated "c-diff reactivated while at hospital." Nurses notes indicated: "5/2/11 at 4 p.m. indicated: "Patient readmitted..diarrhea continues contact isolation for c-diff precautions in room and outside door..." "5/8/11 1200 p.m. ...up to bathroom with wheelchair....diarrhea continues vancomycin and flagyl continues..." "5/11/11 1030 p.m. ...toilets self, uses urinal at times..." "5/12/11 2000 (8 p.m.) propels self in wheelchair, continent of bowel and bladder toilets self..." "5/13/11 1435(2:45 p.m.) continues vancomycin and flagyl for c-diff as ordered. toilets self..." The bowel and bladder chart, indicated the resident had watery diarrhea on 5/3/11 and 5/4/11 and was continent. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident was incontinent of a large amount of stool on 5/6/11. The care plan, included a problem, dated 3/21/11 and updated 5/3/11, for "actual/potential for infection related to IV and cdiff 3/18/11, resolved 4/20/11." Interventions included but were not limited to: 'isolation as needed for policy. contact 3/21/11." The care plan had not been updated to include the need for isolation after the hospital stay, nor did the care plan address the need for either cleaning the toilet after use or for using a bedside commode to prevent the spread of c-diff. 3. Resident #40 was identified on the initial tour of the facility by the Director of Nursing, on 5/16/11 at 9:30 A.M. as being dependant for care, cognitively impaired and having chronic urinary tract infections. On 5/17/11 at 10:30 A.M. CNA #2 and CNA #6 indicated they were going to provide care for the resident. Resident #40 was observed to be transferred from her wheelchair to the toilet. CNA #2 and #6 both put on gloves prior to the transfer. The resident was observed to have been incontinent of urine with the adult			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incontinence brief removed by CNA #6. CNA #6 placed the soiled incontinence brief in the trash can, then left the bathroom, with the same gloves on and got into Resident #39's bedside drawer (Resident 40's roommate), picking up and going through plastic bags of personal items. CNA #6 then went to Resident #40's nightstand and opened the drawer and went through bags of personal items, with the same pair of soiled gloves still on. She then left the room, took her gloves off and went to the central supply room, going through several cabinets to find a bottle of periwash, which she took back to the bathroom. CNA #6 was not observed to cleanse her hands. 4. On 5/16/11 at 9:00 A.M., on the initial tour the Assistant Director of Nursing indicated Resident # 29 had dementia, a history of falls, was up in a wheelchair daily, required assistance of two with transfers and was not interviewable. Resident # 29 was observed at this time to be in bed asleep. On 5/16/11 at 12:50 P.M., Resident # 29 was observed to be in the bathroom in her room. RN # 1 was observed to be wearing a yellow paper gown and gloves. RN # 1 indicated Resident # 29 was in isolation for C-diff.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview with the Education RN, on 5/16/11 at 1:00 P.M., she indicated there are signs that are suppose to be put on the door for staff and visitors to check at the nurses station before entering the room. She indicated she was not sure why there was no sign on Resident # 29's door. In an interview with CNA # 11, on 5/16/11 at 1:10 P.M., she indicated she knew Resident # 29 was in isolation because she had a bedside cabinet outside her room. She stated that is what the facility used to store the needed isolation supplies. She further indicated Resident # 29 had C diff which was the reason for the isolation. On 5/17/11 at 9:45 A.M., CNA #1 and LPN # 1 were observed to put on gowns and gloves before entering Resident # 29's room. CNA # 1 indicated Resident # 29 had c-diff and that is why they needed to wear gowns and gloves when providing care. Resident # 29 was observed to be assisted with ambulating to the bathroom. LPN # 1 was observed to remove a wet incontinence brief from Resident # 29. LPN # 1 then placed the brief in the trash can in the bathroom. LPN # 1 then removed her gown by using her soiled gloves to untie the gown at the neck and at the back. LPN # 1 then removed her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	gloves and then left the room. LPN # 1 was observed to go to the linen closet across from the nurses station and use the hanging key to unlock the door. LPN # 1 then got 3 towels and 2 washcloths out of the closet before shutting the door and returning to the outside of Resident # 29's room. LPN # 1 then got a gown and pair of gloves from the bed side cabinet and put them on. LPN # 1 then took the linen into the room. She proceeded to go to the bed side cabinet in the room located next to the isolation soiled linen barrel which had the lid only partially covering the barrel. The clean linens that LPN # 1 had in her hand was observed to be touching the lip of the barrel that was not covered with the lid. CNA # 1 who had been assisting Resident # 29 in the bathroom was observed to go to a chest of drawers in the room and open 3 of the 4 drawers. She used her gloved hands to move items of clothing around in every drawer. CNA # 1 was then observed to go to the closet and touch several items of clothing and then pull a box off the shelf while still wearing the soiled gloves. CNA # 1 was observed to return to the bathroom and assist Resident # 29 was pericare and dressing. CNA # 1 then was observed to go to the bed side cabinet and open all three drawers and move items around with her soiled gloves. CNA # 1 was observed to touch door knobs, privacy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	curtains, bed, window curtains, the resident's wheelchair, and call light with her soiled gloves on. LPN # 1 was observed to again remove her gown by untying the gown at the neck and back and remove her gloves then leave the room. LPN # 1 was observed to go to the nurses station and get a key to unlock the employee bathroom and wash her hands. CNA # 1 was observed to remove her gown and gloves then hand Resident # 29 a box of tissue then went to the bathroom and washed her hands. CNA # 1 was then observed to push Resident # 29 in her wheelchair, touching the wheelchair handles and brakes, to the hallway next to the nurses station. On 5/18/11 at 8:55 A.M., CNA # 12 and RN # 1 were observed to assist Resident # 29. RN # 1 was observed to have on a gown and gloves. RN # 1 then kneeled down in front of Resident # 29 and give her medication one pill at a time. RN # 1 was observed to touch the wheelchair and resident with her gloved hands in between each pill. RN # 1 and CNA # 12 were observed to assist Resident # 29 to the toilet. RN # 1 was observed to assist Resident # 29 with pulling down her pants. Resident # 29 was observed to void in the toilet. RN # 1 was observed to wipe Resident # 29 with toilet paper and assist with pulling up her pants. RN # 1 then			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was observed to grab the wheelchair by the handles to move it closer. Resident # 29 was transferred to the chair, and RN #1 was observed to use her soiled gloves to apply a velcro belt to Resident # 29. RN # 1 then removed her gown and gloves went to the bathroom and washed her hands. RN # 1 then grabbed the handles of the wheelchair and propelled Resident # 29 to the hallway to sit next to the nurses station. The clinical record for Resident # 29 was reviewed on 5/17/11 at 2:00 P.M. The record indicated Resident # 29 had diagnoses that included but were not limited to atrial fibrillation (a fib), cerebrovascular accident (CVA- stroke) and history of deep vein thrombosis (DTV). The MDS [minimum data set] assessment, dated 3/24/11, indicated Resident # 29 had severe cognitive impairment. Resident # 29 required extensive assistance of two with bed mobility, transfers, ambulation and toilet use. Resident # 29 had fallen one time without injury since the previous assessment dated 2/20/11. A Physician Notification form, dated 3/4/11, indicated "...Pt [patient] having mucus diarrhea, very foul smelling et [and] incontinent bowel over last few days. Do you want test for C-diff?"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The Nurses's Notes, dated 3/4/11 at 1430 (2:30 P.M.), indicated "Pt [patient] up et [and] down most of day. Diarrhea incontinence most of day. N.O. [new order] rec'd [received] to test for C-diff D/T [due to] mucous consistency et foul smell..."

The Nurse's Notes, dated 3/4/11 at 11:00 P.M., indicated "...Took to toilet frequently by staff..."

The Nurse's Notes, dated 3/5/11 at 1430 (2:30 P.M.), indicated "To BR [bathroom] several x's [times] sm [small] loose stool..."

The Nurse's Notes, dated 3/7/11 at 2300 (11:00 P.M.), indicated "...Mucousy stools noted this PM..."

A Physician Notification form, dated 3/9/11, indicated "...bottom excoriated believe D/T [due to] incontinent diarrhea...FYI stool sent today for C-diff."

An Actual/Potential for Infection Plan of Care, dated 3/9/11 and updated on 5/16/11, indicated "Actual/Potential for infection R/T [related to] C-diff 4/15/11..." The interventions included but were not limited to "Contact isolation as needed for policy."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The Nurse's Notes, dated 3/10/11 at 9:45 (no A.M. or P.M.), indicated "Cont [continues] diarrhea with foul smell called lab for C-diff report- positive..."

A Physician order, dated 3/10/11, indicated "Flagyl 500 mg po [by mouth] TID [three times daily] x [times] 14 d [days] C -diff. Contact isolation."

A Physician order, dated 4/15/11, indicated "flagyl 500 mg po [by mouth] TID [three times daily] x [times] 14 days C-diff. Recheck stool for C-diff after ATB [antibiotic] done."

5. On 05/16/11 at 11:22 a.m., LPN #1 was observed to wear gloves while performing an accu check on Resident #15. LPN #1 was observed to not remove her gloves and to not wash her hands before exiting the resident's room.

6. On 05/16/11 at 11:26 a.m., LPN #1 was observed to not wash her hands before putting on a pair of gloves. LPN #1 was observed to perform an accu check on Resident #17. LPN #1 was observed to not remove her gloves nor wash her hands before exiting the resident's room

7. On 05/16/11 at 11:29 a.m., LPN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was observed to not wash her hands before putting on a pair of gloves. LPN #1 was observed to perform an accu check on Resident #16. LPN #1 was observed to not wash her hands nor remove her gloves before exiting the resident's room. 8. On 05/17/11 at 10:10 a.m., CNA #4 was observed to shower Resident #43. The CNA was observed to have removed the residents clothes and brief and to have placed the clothes and brief on the floor of the shower room. 9. On 05/17/11 at 12:35 p.m., RN #1 was observed to wear gloves and a gown while removing a pilgrim hat from a drawer in Resident #29's room and to place the pilgrim hat (device placed in a commode to catch urine or feces) in a commode. RN#1 was observed to assist Resident #29 to pull her slacks down and transferred Resident #29 from the resident's wheelchair to a commode. RN #1 was observed to not wash her hands nor change gloves before assisting Resident #29 to pull her slacks back up and to assist the resident with sitting back down in her wheelchair and to fasten the resident's seat belt. RN #1 was observed to not wash her hands nor change gloves before wiping the pilgrim hat out and placing the pilgrim hat in a plastic bag and opening a drawer to place the hat in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the drawer. 10. On 05/17/11 at 1:00 p.m., CNA #2 was observed to wear gloves to transfer Resident #40, from the resident's wheelchair to the resident's bed. CNA #2 was observed to remove the resident's slacks and soiled brief. The resident was observed to have been incontinent of feces. The CNA was observed to wear gloves while using cleansing wipes to cleanse a large amount of feces from the resident's bottom. The CNA was observed to not remove her gloves nor wash her hands before picking up the resident's slacks and placing them over the resident's wheelchair. The CNA indicated the resident's slacks were not dirty and could be worn again. The CNA continued to not remove her gloves while she covered the resident with a spread and handled the resident's curtain. The CNA was observed to not remove her gloves nor wash her hands while exiting the resident's room carrying the bagged soiled linen. The CNA was observed to handle the door knob to the soiled utility room wearing the soiled gloves and entered the room carrying the bag of soiled linen. 11. On 05/17/11 at 2:50 p.m. CNA #3 was observed to shower Resident #14. During the shower CNA #3 was observed to throw wash cloths used to wash the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident onto the shower floor before bagging. 12. On 05/17/11 at 4:20 p.m., LPN #2 was observed to wear gloves while performing an accu check on Resident #45. LPN #2 was observed to not remove her gloves and to carry the glucometer out the resident's door and to place the glucometer on top of the medication cart before cleaning it. LPN #2 was observed to not wash her hands after removing her gloves. 13. On 05/17/11 at 5:00 p.m., LPN #2 was observed to wear gloves while performing an accu check on Resident #54. The LPN was observed to exit the resident's room and to place the glucometer on the medication cart before cleaning. LPN #2 was observed to not wash her hands after removing her gloves. 14. On 05/17/11 at 5:05 p.m., LPN #2 was observed to not wash her hands before administering medications to Resident #48. 3.1-18(a) 3.1-18(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0465 SS=D	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to maintain intact walls in the dish washing room. This observation was made during 1 of 3 kitchen observations. Findings Include: During initial observation tour on 05/16/11 at 09:20 a.m. with Cook #20 present the dish washing room was observed to have white tile walls. A large brown, peeling, worn spot was observed directly over the sink. Interview of Cook #20 on 05/16 at 9:20 a.m. indicated the worn wall "falls apart when trying to clean." Cook #20 indicated the worn spot had been present for about a year. 3.1-19(b)	F0465	It is the policy of Eastgate Manor to maintain a safe, functional environment for resident and staff. No residents were identified as being affected. The purchase requisition has been approved and supplies have been ordered. Repairs will be completed when supplies received. A one time audit of entire facility has been conducted to identify outstanding environmental issues of identified areas to be placed on maintenance work schedule. Re-education of the maintenance director to include but not limited to conducting facility environmental rounds and identifying any necessary repairs. A list of identified issues will be forwarded to the Administrator on a weekly basis. Identified non compliance will result in one to one education with progressive discipline up to and including termination for failure to follow policy. An environment round compliance audit tool has been developed and will be utilized by maintenance director for environmental rounds. Environmental rounds will be conducted 5 x weekly x 4 weeks, 3 times weekly x 4 weeks, then weekly thereafter to identify environmental issues. Environmental rounds will be	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			taken to the Quality Assessment Committee for review and recommendations.	
F0507 SS=D	The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Based on interview and record review, the facility failed to receive and place copies of lab reports of coagulation testing in the clinical record for a resident who received routine Coumadin (blood thinner) therapy for 1 of 2 residents in a sample of 15. Resident # 29 Findings include: On 5/16/11 at 9:00 A.M., on the initial tour the Assistant Director of Nursing indicated Resident # 29 had dementia, a history of falls, was up in a wheelchair daily, required assistance of two with transfers and was not interviewable. Resident # 29 was observed at this time to be in bed asleep. The clinical record for Resident # 29 was reviewed on 5/17/11 at 2:00 P.M. The record indicated Resident # 29 had diagnoses that included but were not limited to atrial fibrillation (a fib), cerebrovascular accident (CVA- stroke) and history of deep vein thrombosis (DTV). The MDS [minimum data set]	F0507	It is the policy of Eastgate Manor that the facility file in the residents clinical record are dated and contain the name of the testing laboratory. Resident # 29's lab results were obtained and placed on the medical record. A one time 100% clinical record audit of current in house residents was conducted to ensure coagulation lab results were on the medical record. All coagulation lab results were found to be present on the medical record per the physicians order. Licensed nurses were re-educated on the policy and procedure for obtaining and filing resident lab results in the clinical record. Lab tracking sheets will be audited by DON/Designee 5 times weekly to ensure ordered labs are received and place in the clinical record. Identified non compliance will result in one to one education with progressive discipline up to and including termination for failure to follow policy. The DON/designee will conduct a monthly coumadin audit to verify that ordered coagulation lab results have been obtained and are present in the clinical record. Results of the audit will be taken to the Quality Assessment Committee for	06/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 3/24/11, indicated Resident # 29 had severe cognitive impairment. Resident # 29 required extensive assistance of two with bed mobility, transfers, ambulation and toilet use. Resident # 29 had fallen one time without injury since the previous assessment dated 2/20/11. The clinical record lacked the reports for the Protime (PT) and International Normalized Ratio (INR) drawn on 3/27/11 and 4/6/11. In an interview with the Director of Nursing, on 5/18/11 at 2:30 P.M., she indicated she would call the lab and get the two missing lab reports. On 5/19/11 at 9:00 A.M., the Director of Nursing provided the lab reports for 3/27/11 and 4/6/11. She indicated she did not know why they were not on the resident's chart. The policy and procedure for "Laboratory/Diagnostic Test Values-Monitoring," dated 1/2011, was provided by DoN on 5/23/11 at 9:15 A.M. The policy indicated, Document the following in the Nurses Notes, receipt of lab/diagnostic test results, provider notification, new orders received, Provide a copy of the lab/diagnostic test result to		review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155341	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTGATE MANOR NURSING & RESIDENTIAL	2119 E NATIONAL HWY WASHINGTON, IN47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the DON/Designee for reviewing. 3.1-49(f)(4)			